Cheriton Care Centre Limited

Maumbury Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on the 16 and 20 February 2017 and was unannounced.

The service is registered to provide accommodation and residential or nursing care for up to 37 people. At the time of our inspection the service was providing residential care to 35 older people some of whom were living with a dementia.

The service did not have a registered manager at the time of our inspection. The last registered manager of the service had left in May 2016 and the current manager had applied to take on this role. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We inspected Maumbury Care and Nursing Home in November 2015 and there were breaches of regulation related to how people were supported in a personalised way and their dignity respected, how risks were managed and how the quality of care people received was monitored and improved. We rated the home as requires improvement in all areas we looked at. At our recent inspection we found that improvements had been made and people now received care that was personalised and upheld their dignity. There had also been improvements in how risks were managed but these were not sufficient to ensure people always received safe care and treatment. We also found that improvements to how the quality and safety of the care people received were monitored were not sufficient.

Staff understood the plans people had in place to eat and drink safely. The menu offered a variety of main meals and snacks and catered for individual likes, dislikes, allergies and special diets. However, the risks people faced related to eating and drinking enough had not been consistently managed or actions taken in order to minimise the risks. For example: referrals hadn't been followed up, food and drink charts were not being completed consistently and people who had their food pureed did not consistently receive snacks between meals. Staff did not always have accurate information about changes to people's risks.

Auditing systems were in place but they had not always recognised areas that needed improvement. When areas had been identified actions had been taken to improve outcomes for people.

People were supported by staff who felt supported in their roles. Staff received an induction and on-going training that enabled them to carry out their roles effectively. Some training was not current at the time of our inspection the manager shared plans about ensuring this was rectified.

People were supported by enough staff that had been recruited safely and understood their role in identifying and reporting unsafe practice or potential abuse.

People's medicines were ordered, stored and administered safely. Peoples prescribed creams were being administered but not always recorded correctly. People had access to healthcare when it was needed.

People were supported to make choice and determine how they spent their days. Staff supported people to make choices about their day to day care and obtained consent in line with the principles of the Mental Capacity Act.

Care staff were kind, patient and friendly and respected people's privacy and dignity. They had a good understanding of what mattered to people and used this information to support meaningful interactions.

People were supported by staff who understood the information held in their care plans. People and their families were involved in decisions related to their care.

People enjoyed the activities available to them. Some relatives felt that more activity was a priority and the manager told us that they were addressing how best to meet people's needs for meaningful activity.

People, their families, staff and visiting professionals all described the manager and staff approachable. They knew how to make a complaint and felt they would be listened to and any actions needed would be taken. Staff felt appreciated and understood their roles and responsibilities.

We had concerns about risk management and quality assurance in the home. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's identified risks in relation to malnutrition and dehydration had not been consistently managed or actions taken in order to minimise the risks.

People were supported by enough safely recruited staff.

People felt safe and staff understood how to recognise abuse and their role in reporting concerns.

People's medicines were ordered, stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff received an induction and on-going training that enabled them to carry out their roles effectively. Where staff had not updated their training there was a plan in place to ensure this was rectified.

Staff supported people's ability and choices about their day to day care and obtained consent in line with the principles of the mental capacity act.

People had a choice of food and drinks available that reflected their likes and dislikes, allergies and specialist diets.

People had access to healthcare.

Is the service caring?

Good

The service was caring.

People were cared for by staff who valued and respected them.

Staff had a good understanding of people's interests, likes and dislikes.

People had their dignity and privacy respected.

Is the service responsive?

Good

The service was responsive.

People had individual care and support plans that detailed how they needed to be supported.

Where people were at risk of social isolation actions had been put in place to minimise this.

People had the opportunity to participate in activities both inside the home and within the community.

People were confident that if they had complaints they would be listened to.

Is the service well-led?

Inadequate

The service was not well led.

Auditing systems were in place but they did not always recognise areas that required improvements. Where they did identify the need for actions to be taken these were not reliably followed up.

People, their families and staff had the opportunity to provide feedback about the service which led to positive outcomes.

Staff understood their roles and responsibilities and felt involved in the service's development.

Maumbury Care and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 16 and 20 February 2017 and was unannounced. It was carried out by two inspectors.

Before the inspection we looked at notifications we had received about the service. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We spoke with social care commissioners to get information on their experience of the service. We also looked at information we received in the provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with ten people who used the service and three relatives. Some of the people living in Maumbury Care and Nursing Home no longer used words to communicate, we spent time in communal areas and observed how staff supported and spoke with them. We also spoke with the quality lead, operations manager, manager, clinical lead, four care staff and the chef. We reviewed records related to nine people's care. We also looked at records related to the running of the home including: four staff files, management audits, accident and incident records, training records, staff and resident meeting records and records relating to compliments and complaints. After the inspection we spoke with a health care professional who visited the home.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in November 2015 we found breaches in regulation in relation to safe care and treatment and the recording of risk monitoring. The provider had taken action and made improvements in the management of medicines and the risks associated with pressure sores however we found improvements were still required to ensure people's safety.

We reviewed the risks people faced and the support they received to reduce these risks. We found that some areas of risk people experienced were well managed. However, when people were living with multiple risk that were inter related the actions put in place did not always reflect this complexity.

People had their risk of malnutrition assessed on admission to the service using a tool that reflected a range of indicators. We looked at the care five people had received in response to risks associated with not eating and drinking enough and found that although there were systems in place opportunities to reduce risks had been missed for three of these people who also experienced related risks to their skin integrity or continence.

Weights were reviewed regularly and letters had been sent to people's GPs regarding their weight loss however we saw that these had not been followed up despite continued weight loss. We saw that for two people opportunities to discuss people's weight with GPs had been missed when there had been contact.

Charts were not completed sufficiently to monitor intake for any of the people we looked at. For example fluid charts were not always completed, when completed they were not always tallied and when tallied they ranged in total without clear actions. A person who was on a pureed and fortified diet found eating difficult which meant they often did not eat or eat all their meals. They were recorded as stating they were hungry and hadn't had food recently. Their food and drink intake was being monitored but did not record that any snacks were offered to them between meals. We also saw that their records indicated that they had eaten a sandwich on three occasions which would not be possible. We reviewed the records of another person on a pureed diet who was at risk of malnutrition and saw that records indicated they had not been offered snacks either. We also observed them being supported with a mid-morning drink but not being offered a snack although guidance from a speech and language therapist stated they should be offered food: 'a little and often'. We looked at the snacks offered in the home and saw that they did not include an option for people on a pureed diet. We spoke with the chef who confirmed that options were not available on request but not on the snack trolley. This meant an opportunity to increase food intake for people who were struggling to get enough nutrition was missed.

One of the people on a pureed diet was also at risk of developing urine infections. Records relating to their intake of liquids and output of urine were not consistently recorded appropriately. We reviewed this with a senior member of staff who acknowledged that the recording did not appear to be correct. They also told us they would organise a health review for this person.

We met with one of the people who was losing weight whilst they ate in their room. They told us they ate

alone and staff only came to give them their food and to take away the plate. They were struggling to eat and told us "it just falls off the plate" they also told us that the fork was very heavy. We saw that a lot of their meal had fallen on the floor. They told us the staff clear this up for them. This person had a care plan dated December 2016 that said their food and drink should be monitored. We found these charts, to monitor their intake, were not in place and spoke with senior staff about this. They acknowledged the: "system isn't working in prompting actions". The assessment of this person's risk of malnutrition and dehydration had not been reviewed after an audit in November 2016 highlighted that it was incorrectly calculated and should have led to a care plan review.

The management of risks associated with skincare was improving and measures had been put in place to check that people received appropriate treatment to reduce their risk of developing pressure sores. We saw that most people were receiving appropriate care and treatment and lessons had been learned after a person's care had not been appropriate. However, we saw that important information gathered about a person's weight after the purchase of scales used with a hoist had not been used appropriately. The person was noted to be 15kg lighter than previously assessed when weighed in January 2017. Whilst this information had been reviewed against their risk of malnutrition, it had not been addressed in relation to their risk of developing pressure sores and as a result had not resulted in a change in their weight setting on their air mattress. This meant that the air mattress was not being used effectively to reduce their risk of developing pressure sores. We also found that records relating to creams prescribed to protect people's skin were not sufficient to monitor the care and treatment they received. The records included a body map showing staff where creams needed to be applied however we found two examples of creams charts that had not been made available to staff to complete from the beginning of the month. These people needed creams applied daily to protect their skin from becoming sore. We spoke to senior care staff who told us that the creams were applied every day and ensured that the correct record charts were made available immediately.

Senior staff were responsive to the concerns we identified and took immediate action to improve systems. However, some risks identified for people had not been consistently managed or actions taken in order to minimise the risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other areas of risk management were sufficient. For example, risks associated with safe swallowing and mobility were managed effectively. Staff understood specific risks people lived with and had the skills and knowledge to support them safely. One relative referred to falls their relative had sustained and commented: "They have been exemplary. They could not have done anything more." We saw that records indicated referrals had been made and care plans updated appropriately in response to changes in mobility and falls.

People were supported by enough staff to meet their assessed needs in a timely way. We spoke with people and their relatives who visited the service and they told us that there were enough staff and they did not usually have to wait for care or support. One person said: "there is always someone to help you. They are always about." The staff supporting people were recruited safely. We saw that relevant checks were undertaken before people started work, although the organisation's policy which reflected good risk assessment practice had not always been followed when second references could not be sourced.

People told us they felt safe living in the home. One person said "I feel very safe. Everything is wonderful no one is bad tempered." A relative told us: "I am sure (relative) is safe, they let me know if anything happens." Staff were aware of how to identify signs of abuse and the actions they would take if they became concerned about a person's welfare both in respect of safeguarding and blowing the whistle on poor practice. They

were not all confident in their understanding of the processes that protect whistle blowers. The manager told us they would revisit this with the staff team and said: "If a member of staff complained about poor practice it would be investigated but confidentiality respected."

People's medicines were administered safely and they were confident they received them appropriately. One person told us: "They are very good with the medicines very careful." We saw that staff giving medicines to people followed good practice to reduce the risk of errors. Checks were made on the safe storage of medicines and these had been effective in ensuring changes were made when required. This meant that medicines were stored securely at the correct temperature. We checked the medicine administration charts for people and they had been completed correctly other than for prescribed creams.

A process was in place to record and monitor any accidents or incidents. Records showed us that the manager reviewed all accidents and incidents. Any actions needed to minimise any further risks had been taken and included other professionals appropriately. For example we saw that people had been referred for reviews of their medicines and related care plans had been updated.

Good

Is the service effective?

Our findings

When we last inspected the service in November 2015 we found a breach in regulation in relation to ensuring people's food choices were met. The provider had taken action and made improvements in relation to choices available.

People told us the staff had the skills they needed. One person said: "They know what they are doing. I am confident of that." Another person said: "Oh they are very good at their jobs." Staff received an induction and on-going training and they told us this training supported them to carry out their roles effectively. New staff were enrolled on the Care Certificate induction standards. The Care Certificate is a national induction programme for people working in health and social care who do not already have relevant training. We spoke with a newly employed care worker who told us: "My induction is very good. I am still learning – I have learned a lot but I can still ask questions." Care staff described the training as relevant to their roles. For example the staff with management responsibilities had access to management training as part of an induction in their roles. We heard that this enhanced their skills. They felt they had the competency they needed and explained they could ask for support whenever necessary. We looked at the training records and saw that a number of staff were overdue training that was deemed essential for their roles by the provider. This meant that they may be working without knowledge of current good practice. We spoke with the manager about this and they identified how these training requirements were being met.

Staff told us they felt supported. We saw that staff used the supervision process to identify their training needs through discussion about the needs of people and their own professional development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service was working within the principles of the MCA. Staff supported people's ability and choices about their day to day care. Most of the people living in the home were able to make some decisions about their care and they did so throughout our inspection. We observed staff seeking consent and giving people time to make decisions. Staff were able to explain how they sought to understand people's wishes when they did not use words to communicate. One member of staff explained: "You look at people's facial expressions sometimes the answer is in the roll of an eye. If they don't want it you don't carry on." We saw that consent forms in people's care files had been signed by people in relation to aspects of their care. When people had not had

the capacity to sign for themselves families had been involved in consenting. Where decisions had been made in a person's best interest they had included family and professionals who had knowledge of the person's history in line with the principles of the MCA. We also saw that the principle of seeking the least restrictive option was evident in decisions for example one person was taking their medicines covertly and this had been agreed to be the least restrictive option available in their best interests.

People and their families told us that the food was very good. One person told us: "The food is fantastic. Another person said "I think the food is wonderful. They bring me breakfast just the way I like it when they see I am awake." We visited the kitchen and spoke with the chef. The information they held about peoples dietary needs, likes and dislikes reflected what was in people's care and support plans. We saw that people were offered choices and that the mealtime downstairs was a social event for people. The information included people who were having their food fortified to support them to gain or maintain their weight. Concerns highlighted during our inspection about the choice of snacks available to people on pureed diets were addressed by the chef and a plan put in place to ensure options were available.

People had access to healthcare when it was needed. Records were kept of professional visits and included the GP, district nurses, occupational therapists and chiropodists. People told us they were supported in accessing the healthcare they needed. One person told us; "I am so much better than I was… Pain is under control here."

Good

Is the service caring?

Our findings

When we last inspected the service in November 2015 we found breaches in regulation in relation to how people were consulted about their care and the language used to describe the people and the care they received. The provider had taken action and made improvements in these areas.

People and their families described the care staff as caring and kind. People made comments such as: "There is nothing they wouldn't do – I only have to ask." and "The staff are lovely – we get on very well." A relative commented that the staff had "endless patience". The manager had recently received a compliment from a relative stating: "My relative could not have had better care if they were the king of England."

Staff liked and cared about the people living in the home and this was evident in many interactions and the way they spoke about people with us. For example we saw a member of staff taking time to rub a person's back whilst they spoke with. The person clearly appreciated this physical touch supporting their communication. This was demonstrated in all the interactions we saw during our inspection and was reflected in the comments made by people and relatives. One person told us: "They are lovely and I can turn to quite a few of them if I need a shoulder to cry on." Staff had a good understanding of people's interests, likes and dislikes. We observed that this provided the basis for conversations about people and places that mattered to people. One member of staff reflected on the importance of developing good relationships as a motivator for their work; telling us: "It is so rewarding to make someone's day."

People and their families told us they felt involved in decisions. People were offered choices that promoted their independence such as: where they sat; which rooms they spent time in; whether they spent time with the activities coordinator and/ or joined in communal entertainment and what time they got up and went to bed. One relative told us "They always tell me what has been going on. They have got it right." We read minutes of resident/relative meetings where discussions had included the laundry, making complaints, and activities.

People had their dignity and privacy respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. People's clothes were clean and bedrooms were tidy and reflected individuality.

We saw staff taking time to talk with people to develop positive relationships by making a connection in ways that were meaningful to people. For example we observed people whose mood could change quickly being supported by staff who understood when to reassure them and when to give them space. This person centred approach had a visibly calming and mood enhancing effect on people.

Good

Is the service responsive?

Our findings

When we last inspected the service in November 2015 we found that care was not designed to meet people's preferences and needs and there was a breach of regulation. At this inspection we found improvements had been made.

Assessments had been completed before a person moved into the service and this information had been used to form their care plan. The plans contained clear information about people's assessed needs including how they communicated and the actions staff needed to take to support people. We observed people receiving care as outlined in their care plans. For example people were supported to use equipment safely to help them get around the building. Care plans were reviewed monthly and staff told us they provided them with the information they needed to provide person centred care. We saw that personal information was recorded such as information that could cause a person to worry and drinks that would make a person smile.

Staff told us that they had a handover to ensure that important and emerging information about people's care needs was shared. We saw that they completed daily records to inform this handover which included comments about people's mobility, wellbeing, personal care, activities and any visits they had received from professionals.

People who were at risk of social isolation had a care plan detailing actions to be taken to reduce the impact of this risk. We spoke with three people who spent most of their time in their bedrooms. They told us that this was their choice and they preferred to spend time alone. They also told us that staff spent time with them and we saw that the member of staff who did one to one activities with people spent time with them doing things they enjoyed. There were activities such as adult colouring books and puzzles available in boxes throughout the home and we were told by staff that they were used by people with support from staff and visiting relatives. Another person told us: "There are things going on – there is a singer in later". A member of staff told us that one of the people who had recently moved in loves cricket and plans had been made to ensure they could attend a game at the club nearby once the cricket season began. There were mixed views regarding access to meaningful activity and two relatives commented that there was not always enough to do. We discussed activities with the manager who explained that they were reviewing activities as a senior member of staff who had been very involved in this area of people's lives had left shortly before our inspection.

A complaints procedure was in place and we saw that where complaints had been made the procedure had been followed. People and relatives all told us they were comfortable talking to any of the staff about any concerns or complaints they may have. One person said "I would be comfy to talk to them if I had any concerns." One relative told us they had felt comfortable making suggestions and had felt heard. We saw how to complain had been discussed at a residents' meeting by the manager. This open approach was reflected in people's willingness to complain if they felt it necessary.

Inadequate

Is the service well-led?

Our findings

When we last inspected the service in November 2015 we found a breach in regulation in relation to quality assurance processes. Records were difficult to find and audits were not completed or ineffective in securing positive outcomes for people. We received an action plan outlining how the requirements of the regulation were met at the time that this plan was submitted in March 2016. The provider had taken action however we found improvements were still required to ensure people's wellbeing and safety were monitored effectively.

At our November 2015 inspection we also identified breaches of regulation related to risk management, respect and person centred care. We judged that Maumbury Care and Nursing Home required improvement in all five areas we look at. At this inspection, we found improvements had been made resulting in three of the areas we look at being rated good. The way staff worked to provide person centred care that supported people's dignity and respect was now compliant with regulation. The oversight of the home since the November 2015 inspection had not, however, been sufficiently effective in making adequate improvements to the quality and safety of care people received. As a result there were continued breaches of regulation related to the safety of care and treatment and the governance of the home. People remained at risk because actions described in the action plan were not being carried out. For example the action plan stated that food and fluid charts would be checked as part of a twice daily walk round to ensure they were being completed and used effectively. We found that this action was not effective because the information in the charts was not being consistently tallied and used to plan people's care and treatment.

There were systems in place to review and audit the care and treatment people living in Maumbury Care and Nursing Home received. These were undertaken by senior managers from within the provider organisation and the home. We found examples of these highlighting issues and leading to appropriate action however these systems had not always recognised areas that needed improvement to ensure the best outcomes for people. This included areas of risk in relation to people's weight found at this inspection.

Systems to monitor people's nutrition and hydration were not effective. An audit had been carried out monthly which had not identified concerns. The operational manager told us that they had also found this audit to not be effective and shared this with the manager the week prior to our inspection. The manager reviewed and redid the audit for January 2017 after we highlighted concerns that it had not been completed accurately on the first day of our inspection. They agreed that it had not been accurate and that food and fluid charts were inconsistently completed. They addressed these concerns with an action plan that care plans would all reflect MUST scores accurately (MUST is a tool for measuring people's risk of malnutrition and dehydration). It also stated that condiments would be provided with food served in people's rooms.

Whilst it was positive that the provider's February audit had picked up that the home's nutrition audit was not effective, concerns had also been identified in the provider's previous audit in November 2016. At this time it was noted that MUST scores were incorrect for one of the people who was losing weight. This had not led to a change in their recorded MUST in their care plan. It was also identified that it was not clear that recording was not consistent. Actions related to correct MUST scores and consistent recording of nutritional intake were recorded as being done and on going on 20 January 2017. This finding was not sufficiently

monitored by the provider and a further opportunity was missed to reduce the risk to people. The action plan created after our last inspection in March 2016 and the action plan created by the provider in November 2016 had not led to improvements in the management of risks people faced related to not eating and drinking enough.

Care plans had not been audited since our last inspection. The action plan submitted following our last inspection stated that this was done on a monthly basis. This had been identified by the provider audits of November 2016 and February 2017. The February 2017 audit highlighted that this was being done at the time of the audit. We asked the operational manager about this and they told us that one care plan had started to be audited but this had not been completed. Care plans were, however, audited by the operational manager between our first and second inspection visits. These audits identified a number of actions that were necessary to ensure that care plans reflected people's current need appropriately. These audits also identified a number of the concerns identified during our inspection such as the need to tally food and fluid charts. However, we also saw that the care plan audit did not identify any concerns for a person whose nutritional care plan had been highlighted as needing review in the November 2016 provider audit. These audits had not provided effective quality assurance as due to their delay, their failure to review in conjunction with audits done previously, and areas they had missed they had not led to action being taken to improve the quality and safety of the care experienced by people living in the home.

The oversight of nursing was not effectively assured through the systems and structures in place. The clinical lead had received supervision and development support from the provider's quality lead and whilst the manager was aware of this they did not have written records provided to them. It is important that managers without clinical expertise maintain oversight of clinical issues to ensure the quality of the service people receive.

Systems and processes were not always effectively monitoring and reducing risks to people related to their health and welfare. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a condition of the registration of the home that it has a registered manager. At the time of our inspection this condition was not being met as the last registered manager of the service had left in May 2016. The current manager, who was registered to manage the home next door to Maumbury Care and Nursing Home, had applied to the CQC to take on this role.

People's feedback was sought as part of the quality improvement processes in the home. Regular meetings afforded people the opportunity to discuss issues of concern to them and we saw that these were recorded and action taken. For example additional staff hours were allocated to the laundry after concerns were raised at meetings. We also saw that individual concerns were identified from the annual resident and relative surveys and action recorded to address any areas for improvement. A major refurbishment had been carried out with substantial building works to oversee. People had been kept informed about this and the manager had worked to ensure minimal disruption to people's lives.

People, their relatives and staff all described the manager as someone they could talk to who got things done. One person said "They are nice. They will have a chat". We saw that the manager knew people as they walked around the building and that people were comfortable to talk with them. A relative told us "We often see the manager. He has been good with us and gets things done." Another relative commented: "They are approachable." We spoke with staff who spoke positively about the management. One said "I can always ask them questions." We spoke with the local authority quality improvement team who were positive about the manager's experience.

The manager understood their responsibilities for sharing information with CQC. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Staff, people and relatives held the service in high regard. One person said: "I wouldn't go anywhere else." A relative reflected on changes they had seen and told us the home was: "greatly improved – they have got it right". Staff they understood their roles and felt involved in the development of the service. Staff meeting minutes reflected a culture of open discussion with agenda items related to improving care practice and organisational issues.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were at risk of harm because the risks they faced were not assessed adequately and these risks were not adequately mitigated. Regulation 12 (1) (2) (a) (b)

The enforcement action we took:

We served a notice of decsion to vary the conditions of registration and required the provider to report to the Care Quality Commission about the safety of people's care and how this was being monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Auditing systems had not recognised areas that required improvements to ensure safe care of people. Regulation 17 (1) (2) (a) (b) (c)

The enforcement action we took:

We served a notice of decsionl to vary the conditions of registration and required the provider to report to the Care Quality Commission about the safety of people's care and how this was being monitored.